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ABSTRACT

This paper reviews the rationale for social network programs in the effort to deinstitutionalize the mentally ill. Stress and mental health problems are discussed in terms of biological and social determinants, measurement techniques, and coping mechanisms. Supportive relationships as buffers to stress are examined and the concepts of social networks and social support are distinguished. Social support groups such as the family, small socio-ecological systems, and large socio-ecological systems are discussed. Social support factors that guard a former psychiatric client against future rehospitalization are identified. A case example and a discussion of implications for intervention conclude the paper. (LLL)

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The Importance of Social Networks in De-Institutionalization

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Running Head: IMPORTANCE OF SOCIAL NETWORKS

The Importance of Social Networks in Deinstitutionalization

Richard B. Weinberg

Mental health care has evolved from the traditional medical model. This model places unquestioned importance on there being a well-trained professional care-giver at the core of service delivery. This view of treatment has received considerable criticism and refinement of late. Most notably a number of studies have demonstrated the beneficial effects of natural support systems and social networks in the prevention and rehabilitation of mental and physical problems.

It is becoming clear that many de-institutionalized people return to an environment which is similar to the one they were in preceding hospitalization. It is also known that people in need of help turn first to family, friends and others not affiliated with the professional medical establishment. These two factors magnify the importance placed on a de-institutionalized patient's social network or support system. That is, the support system often represents the front line of defense for the de-institutionalized person, in terms of stress coping, adjustment and referral. The network's importance is underscored by several recommended policy statements, including a report submitted to the President's Commission on Mental Health, a number of national conferences and numerous journal articles which have called for the increased study and use of natural support systems and social networks.

The purpose of this chapter is to review the rationale for social network programs in the de-institutionalization effort. To this end, this chapter will discuss the following topics:

1) stressful life events and mental health problems;

2) social support as buffer of life stress;

3) sources of social support;

4) brief review of the literature on mental health service user's social support systems;

5) a case example; and

6) implications.

Stress and Mental Health Problems

The traditional model of disease holds that a person gets sick when infected by some type of infectious agent. In addition to biological determinants, a number of social factors have also been found to play an important role in disease susceptibility. One such factor is environmental stress. Hans Selye has identified three stages of stress reactions: 1) the alarm reaction; 2) stage of resistance; and 3) stage of exhaustion. The alarm reaction occurs immediately after an environmental stimulus has been perceived as threatening or harmful. A number of bodily reactions occur at this stage, among them are increased blood pressure, heart and respiration rate and muscle tension. These body changes serve an adaptive purpose. They better prepare an individual to face the threatening stimulus. However, if the stressful stimulus persists these enhanced physiological processes continue. If these continue over a long enough time, Selye's second and third stages of stress will

occur. In these stages a breakdown of bodily functions can take place, with such results as hypertension, ulcers, headaches and, some believe, cancer and death.

In order to measure the amount of stress an individual has experienced, researchers have developed a number of scales. These scales approach the measurement of stress by asking the respondent about the number of stressful life events they have recently experienced. Respondents are asked, for example, whether they have recently experienced the death of a family member, losing a valuable object, a divorce or breakup with a lover, being fired or laid off, financial problems, being involved in a violent act, etc. Numerous studies have found a significant relationship between stressful life events such as these and a variety of physical and emotional problems.

Serious psychological problems such as prolonged depressive episodes and schizophrenia are among the difficulties that have been found to have a positive relationship to stressful life events. While research in this area is far from conclusive, a number of tentative conclusions can be drawn: 1) stressful events which are beyond an individual's control contribute to psychiatric and emotional difficulties, 2) heredity and stressful events can combine in such a way that close relatives of mental health clients, by acting strangely, can create stressful events which adversely affect the client; and 3) stressful circumstances lead to demoralization which, in turn, may decrease self-confidence and heighten the likelihood of a psychiatric disturbance.

A very interesting question can be raised, however, regarding the life stress-illness link.

Why is it that many people, in particular many people who are at high risk for a psychiatric disturbance, can experience many stressful life events and remain relatively free from disturbance? One of the answers to this question can be found in terms of coping ability. Many types of coping exist, ranging from intra-psychic mechanisms such as denial and sublimation to the use of social skills such as problem-solving and assertion. One of the most important moderators of life stress that research has identified is the helpful support that emanates from friends, relatives and other significant people in one's environment. Broadly, this is known as social support.

Social Support as Buffer of Life Stress

The belief that social relations can act to diminish the harmful effects of life stress has been proposed by representatives from several academic disciplines including anthropology, sociology, psychiatry, epidemiology and psychology. Supportive relationships are thought to act as buffers in that they lead a person to believe he is loved, esteemed and part of a group which mutually exchanges needed emotional and material resources. As various situations arise which cause undue strain or anxiety, the active presence of support is believed to provide a person with various means of coping with the stressful event. These means of coping may include concrete assistance, such as food, money or clothing; or personal support in the form of labor, listening, advice or love. It is of further importance to note that the presence of support may not only moderate personal strains <u>following</u> a stressful occurrence, but it is also thought that the ongoing give-and-take of supportive interactions within a social network will serve to prevent minor upsets from becoming harmful

stressors.

Social networks and social support have been used synonymously thus far in this paper. It is important however to distinguish these two concepts at this time.

Social Networks

The development of theory and research in social networks has evolved primarily from anthropology. A network has been defined as "a specific set of linkages among a defined set of persons..." A diagram of a social network would consist of a number of points joined by lines. The points would represent people, with the lines representing some type of relationship between these people. The lines may represent, for example, a flow of information, a path where certain material goods are exchanged or the existence of friendships.

Various types of networks exist. The one most often used in mental health is the ego-centered network. This consists of one individual and everyone whom this person knows and/or interacts with. An ego-centered network has many properties which may be analyzed, such as: 1) size, the number of people in the network; 2) density, the extent to which people within the network know one other irrespective of the person at the center; 3) reachability, the extent to which a network member can communicate with another given member; and 4) reciprocity, whether and to what extent goods, information or any other material flow in one or two directions between network members. Hence, the concept of social network is quantitative, unlike that of social support which is more qualitative.

Social Support

This concept has been defined in several ways in the literature. All of the definitions agree that social support differs from the social network concept by focusing not on the number of relationships a person has, but more on what is exchanged among people within a network. Further, what is exchanged must be perceived by the recipient as beneficial, otherwise it cannot be support.

A number of studies have attempted to classify the various dimensions of social support. Summarizing their findings, it appears that support can be broken down into the following social resources: 1) material assistance; 2) social interaction; 3) intimacy/trust/affection; 4) concern and reassurance of worth; and 5) information and advice. Thus, whether and to what extent social support is exchanged is "in the eye of the beholder", i.e., it is a perception and is therefore subjective.

To summarize the distinction between network, support and support system:

1. An ego-centered social network is seen as all those individuals whom a focal person knows and with whom this person interacts, with no implication as to the quality of the relationship between the individual and the network members.

2. Social support is conceived as any material, informational or emotional resource which, when exchanged among individuals, is perceived by the recipient as beneficial. The resource exchanged may include: 1) material goods; 2) social interaction; 3) intimacy and trust; 4) reassurance of worth; and/or 5) information and advice.

3. A social support system is that subset of the social network which is a source of social support for the focal individual.

Sources of Social Support

Social support emanates from a variety of groups. The following section provides a brief selective review of the literature in this area. Relevant citations are provided in this section for the reader interested in pursuing this topic further.

Social Support in the Family.

The beginning of any investigation into the importance of a social support system must begin with the most natural of support systems -- the family. Archaeologists have found evidence that human family life existed well over 100,000 years ago, with social interactions of that day including mutual helping behaviors (Vallois, 1961). Washburn, Hamburg and Bishop (1974) have noted that for over 99% of the time man as a species has existed, he has lived in small, family-type groups, which have provided him with many survival-oriented benefits.

Many contemporary authors have found the family to be the primary source of help when stressful life events occur. Sussman and Burchinal (1962) report that people in need of help are much more likely to call on extended family members than to call on social agencies or other professionals. They identify two types of support provided by the extended family: 1) mutual aid, including the exchange of services, advice, material goods and financial assistance; and 2) social activities such as interfamily visits, recreational pursuits and family ceremonies. Leichter and Mitchell (1978) found that 95% of the 298 nuclear families they interviewed re-

ceived some type of assistance from their extended kin and 94% returned it. The findings of Babchuk and Ballweg (1971) allow further generalization of these findings to black families, whom they found also made considerable use of their extended families. Most recently, Colten and Kulka (1979) report the findings of a large scale interview (N = 2264) conducted by the Institute for Social Research in 1976-77. They were interested in assessing the nature and perceived helpfulness of naturally-occuring and professional support. They found that 73% of the naturally occuring sources of support to whom respondents went when they had a problem were family or extended family. The most common helping responses of the family member was to listen, cheer up and/or comfort the respondent.

Caplan (1976) describes eight theoretical ways in which the family provides support to its members: 1) it collects and disseminates information about the world; 2) it provides honest easily understood feedback to its members; 3) it is a major source of tradition, beliefs, values and codes of behavior which enable a person to understand the world, and moreso helps one adapt to various stresses such as war and personal misfortune; 4) it is a guide and mediator in solving problems; 5) it is a source of practical services and concrete help when family members are in need; 6) it provides a sanctuary for rest and recuperation; 7) it is a reference and control group; and 8) it is a source and validator of personal identity. While Caplan's formulation is thought-provoking and lends itself well to policy-planning, his thoughts are quire conjectural and fail to fully consider the negative impact that certain families may have on their members.

Tolsdorf (1978) studied life stress, social adjustment and social network contact in 11

single-parent and five intact families who had recently experienced some form of family discord, substance abuse or physical abuse. Contrary to prediction he found that family and network contact was highly correlated with life stress. This finding was interpreted as providing evidence that the family and other social contacts in these multi-problem families have failed to provide support.

Poor family life is often mentioned in the etiology of schizophrenia. Bateson, Jackson, Haley & Weakland (1956) propose a theory that conflicting communication in the patient's family will contribute to this disorder. Other authors elaborate on and attempt to test this theory (see Yeomans, Clark, Cockett and Gee, 1970 for a summary of this literature). However, while family life may be instrumental in the etiology of schizophrenia, there appear to be optimistic findings regarding the de-institutionalized patient returning to his or her family.

Blumenthal, Kreisman and O'Connor (1982) examined the living arrangements to which over 20,000 formerly hospitalized patients in the state of New York were discharged. They compared re-hospitalization rates of those patients who lived alone, with parents, spouse, other relatives or friends, or in a domiciliary setting. They found that patients who went to live with a spouse were re-hospitalized significantly less often than those returning to any of the other settings. These results are explained by the authors, in part, by referring to the presence of supportive social networks in the home setting.

It is difficult, if not impossible, to infer that the family, per se, is the active element in preventing re-hospitalization. A more fruit-

ful approach is to analyze what aspects of the family are associated with better or worse outcome. Brown, Birley and Wing (1972) examined the family interactions of 101 schizophrenic patients after discharge from a psychiatric hospital. Through a series of several interviews with the families, both pre- and post-discharge, they found that families who tend to express a great deal of emotion in the household are most likely very critical families. Furthermore, 58% of those patients whose families had high degrees of expressed emotion had a relapse of psychiatric symptoms, whereas only 16% of those patients whose families had low expressed emotion had a relapse. The arrows of causality, however, are not one-way. That is, they found that the patient's symptomatology will often affect the expressed emotion from the family. Finally, positive aspects of the family's affective expression were also found. Families who expressed even mild degrees of warmth significantly decreased the likelihood of a patient's relapse.

Thus it appears that a qualitative analysis of family interaction patterns would provide a fruitful approach to the study of support.

While the family may be very important, a person finds social relationships in a number of other social settings. The next two sections will briefly examine other potential sources of social support.

Social Support in Small Socio-ecological Systems

Good relationships on the job have been found to be important factors in work productivity and mental health. Wellman (1977) in a study of the "intimate ties" of 845 Toronto adults, found that co-workers were relied on for help in ev-

eryday matters more than any other relationship type, including kin and friends. Other studies have similarly found that social support on the job plays a very important role in helping workers cope with job stresses and strain.

Observational studies of combat units during World War II examine the effects of support among soldiers. The experience of war-time combat is undoubtedly one of the most acute, intense stressors to which man can be subjected. Several World War II studies (Bartmeier, Kubie, Menninger, Romans and Whitehorn, 1946; Shils and Janowitz, 1948; Swank, 1949) examined the condition of combat exhaustion and discussed the possible preventive effect that social support within the small military unit might have. While based only upon observations, these authors comment on such factors as the development of group identification, cohesion and pride in units with a low incidence of exhaustion. They go on to compare the high rates of fatigue in reinforcement troops who entered the conflict knowing no one in their new divisions, characterized by Bartemeier, et. al., (1946) as "stripped of many of the emotional satisfactions and supports needed for military effectiveness" (p. 516). Thus the presence and protective nature of social support is one possible conclusion of these observations.

This sampling from the literature explored the potential which worker groups and soldiers have for providing social support. The next section will examine the presence of material and emotional resources within larger systems.

Social Support in Large Socio-Ecological Systems

Socio-cultural variables and the effects they may have on psychological functioning are the topic of a review by Liem and Liem (1978). They integrate several bodies of knowledge including the effects on mental health of such societal pressures as economic change and unemployment, as mediated by interpersonal relationships and available material resources. They conclude that socio-economic status (SES) is an important moderating variable of these inter-relationships. At lower SES levels, less access to material resources results in less protection against social stress which, in turn, results in relatively poorer mental health.

Matsumoto (1970) writes about the Japanese culture and those qualities inherent in it which he believes protect against stress-related disease. He points out that a consistent social trait of the Japanese, shown in numerous socio-cultural studies is the emphasis on the group, as compared to the Western emphasis on the individual. This is especially evident in the work setting, as Matsumoto cites many qualities of the paternalistic nature of the Japanese business firm and how this breeds a strong in-group solidarity and security within a company.

The Israeli kibbutz is another large socio-ecological setting which is seen by many as inherently supportive. Eden, Shirom, Kellerman, Aronson and French (1977) cite research depicting kibbutz members as better adjusted than the general population in a number of ways. These authors propose that the absence of expected relationships between stressful conditions and psychological reactions in a kibbutz can be ex-

plained by the supportiveness of the kibbutz society. To test this hypothesis they measured the relationship between: 1) various environmental stressors, such as work overload, role conflict, powerlessness, and strenuous working conditions; 2) numerous psychological variables, including anxiety, psychosomatic complaints and job dissatisfaction; and 3) coronary heart disease (CHD) risk. Based on a sample of 1138 healthy male kibbutz members between 35 and 60 years of age they found very low positive correlations between stressors and psychological strains and virtually no correlation (none out of 116 correlations were greater than .12) between stressors and physiological strains. The authors find these results as supporting the hypothesis that the supportive society of the kibbutz operates as a protective factor in mediating the harmful effects of stress. However, the responses of kibbutz members were not compared to those of non-kibbutz members. Furthermore the authors comment in a footnote that this sample was divided into those with high and low social support but no stress-health relationship differences were found between the two groups. Therefore, it appears that the following conclusions: a) a kibbutz society is more supportive than the general population; and b) that this support buffers stress-health relationships, are as yet only speculative.

One final socio-ecological setting in which help-giving has been documented is the neighborhood. Several authors discuss the mutual support and exchange of services among neighbors from an observational point of view (Bracey, 1964; Fava, 1956; Gans, 1962; Keller, 1968). More recently two large scale epidemiological studies have looked at mutually supportive activities in the neighborhood. Wellman (1977) collected data on a random sample of 845 subjects' intimate net-

works. These people were asked about the six people outside the home to whom they felt "closest". While the major thrust of their research was directed to analyzing the nature and effects of various types of intimacy, some of their data is relevant to the question of social support in the neighborhood. People's requests for two types of assistance were examined, common needs and emergency crisis needs. During emergencies neighbors, by virtue of their geographical proximity, were relied upon more often than any other relational type, except for parents and children. However, for everyday needs there was no relationship between proximity and helping. Warren has looked more closely at neighbor-based helping (Warren, 1976; Warren and Warren, 1977). He analyzed the responses of over 1700 Detroit-area households on the basis of a neighborhood typology. He bases this classification on three factors: community member's interactions with each other, their links to others outside the community, and the strength of an individual's identification with the community. He found that various neighborhoods differ greatly on the amount of support their residents exchange with each other. In one type of neighborhood, which Warren calls Parochial, the frequency of neighbor help is very high. Conversely, in other neighborhoods, helping, as well as other interactions are very rare. Thus, whereas neighbors may be a potential source of support, in some neighborhoods they are infrequently used.

The preceding section discussed a number of the various sources of social support. Whereas it was pointed out that the potential for social support exists for everyone, there are those who remain isolated from others, and some who, despite their presence within a social network of family and friends do not participate in the

sharing of mutual aid. This raises several questions relative to the de-institutionalized person, for example, will the lack of social support have a negative impact on well-being, and conversely, to what extent does the presence of support buffer one against the harmful effects of life stress? The next section will begin to address these and related issues by selectively reviewing a number of relevant studies. The interested reader is referred to a number of other sources for a more thorough review of this area (Cohen & McKay, 1981; Gore, 1981; Heller, 1979; Mueller, 1980; Pilisuk, 1982; and Weinberg, 1980).

Social Support and the Mental Health Client

In an effort to identify the factors that prevent a former psychiatric client from future re-hospitalizations Strauss and Carpenter (1972; 1977) followed 131 subjects over 5 years. Several measures were used and they found that the number of social contacts a patient had, defined as the frequency with which they met with friends, was the best predictor of positive outcomes.

Pattison and his colleagues (Pattison, Llamas & Hurd, 1979) compared the social relationships of psychiatric clients of differing diagnostic categories with non-clients. They found quantitative as well as qualitative differences among the groups. The major differences were seen in three areas: size, density and quality of the relationship between the subject and network members. Basically, the network size of non-clients ranged between 20-30 people with a density (i.e. roughly the percentage of people who know one another) of approximately 60% and the quality of the relationships rated as good.

The network size of clients classified with a diagnosis of neurotic averaged 15 with 30% density and the relationship quality rated lower than those of the non-clients. The authors characterize this type of impoverished and isolating network as resembling a wagon wheel with the neurotic subject at the center.

Individual relationship "spokes" stick out with a broken rim failing to connect the spokes.

The clients classified with a psychotic diagnosis differed still further. This group tended toward a network size of between six and 12 people, composed of primarily family. Density was very high, often 90% or higher. Interpersonal relationships were characterized by ambivalence and negativism. They conclude from these results that the psychotic is

> caught in and tyrannized by a collusive closed system, with few links to the larger communities of relationships. This social system cannot process high degrees of stress that are readily transformed into anxiety and symptom generation. Further the system produces conflicting emotional messages and contradictory and confusing instrumental behavior between members of the system. Thus this system both generates and augments stress and anxiety, while remaining vulnerable to ambient stress.
> (Pattison, et.al., 1979, p. 481).

Tolsdorf (1976) compared the networks of ten recently hospitalized, first admission psychiatric subjects with ten subjects who were recently hospitalized for non-psychiatric, medical reasons. Using as a criterion for membership in the social network that a subject and the network member know each other by name, have an on-

going personal relationship and have contact at least once a year, Tolsdorf found no differences between these two groups on size or density. Using a more intensive structured interview method, he found the network size of the medical group to be 38, the psychiatric group, 30, and the density of both groups to be similar to Pattison, et.al.'s density figure for his normal group. However, when analyzing the type of relationships which make up the respective networks of each group, three of Tolsdorf's findings parallel those of Pattison. First, the psychiatric group's network was 64% family, whereas the non-psychiatric's were only 38% kin. Furthermore, the non-psychiatrics had three times as many multi-functional links than did the psychiatrics, which is one measure of the closeness or intimacy of a relationship. Finally, Tolsdorf found the balance between support given and received by members of each group to be significantly different. Non-psychiatrics had proportionally twice as many symmetric, or equally balanced relationships than the psychiatric group, who tended to receive more support from their network members than they gave.

Garrison's (1978) predominately qualitative analysis of schizophrenic and non-schizophrenic Puerto Rican women's networks further supports the hypothesis that psychiatric clients' networks are more kin-dominated, one-sided and less intimate than the non-client network. She studied five qualitatively different groups of women ranging from those with no medical complaints and no history of psychiatric treatment to in- and out-patient schizophrenics with several previous hospitalizations. She found that the schizophrenic women's networks tended to be characterized by overly-dependent relationships with people either older or younger than themselves in contrast to equally-balanced, peer relationships. In a finer-grained analysis of

those schizophrenic women who lead relatively successful and unsuccessful lives, based on number of hospitalizations, she found the major discriminating feature to be more reliance by the more successful women on neighbors, friends and other non-kin than on family. These findings further support the conceptualization of psychiatric client's networks as domineering and kin-dominated.

Methodologically, the strongest data come from a study by Sokolovsky, Cohen, Berger and Geiger (1978). They studied the network characteristics of a population of predominately exmental hospital residents who lived at the time of study in a single-room occupancy (SRO) hotel. Residents were divided into three groups based on their psychiatric diagnosis and present symptoms: 1) schizophrenics with active residual symptoms (SR group); 2) schizophrenics with minimal or no symptoms (S group); and 3) those with no known history of psychiatric disorder (NP group). As did Pattison, they found the NP group to have more personal relationships than the two schizophrenic groups. Both the SR and S groups had impaired ability to form reciprocal (i.e. where support flows in both directions) and multi-functional relationships, (i.e. where one relationship provides a number of different types of support) and tended to be more dependent than was the NP group. Further, the authors found that the non-symptomatic schizophrenic group tended to be less dependent, capable of more reciprocal relationships and more likely to be seen as tenant leaders than those residents with active symptomatology. With regard to density, they compared those who were rehospitalized often to those who were not. They found, in contrast to Pattison's findings that the density of the hospitalized group was 50% less than the non-hospitalized group. They conclude that

people with small, loosely-connected networks represent an at-risk group with regard to crisis support.

To summarize, these findings lead to the conclusion that psychiatric clients, much moreso than non-psychiatric, tend to be either extremely isolated or enmeshed in and overly dependent upon small, family-dominated networks. As the client improves, there is a corresponding (although not necessarily causative) change in their networks and support systems. The networks become less kin-dominated with relationships becoming established with a greater variety of people. Relationships within the network can be characterized as being more multi-functional and encouraging less dependency.

A Case Example

Sokolovsky, Cohen, Berger & Geiger (1978) report the case of A.P. a man with a history of many previous hospitalizations who came to live in a single-room occupancy hotel in New York City. The extent of A.P.'s social network at this time consisted of his mother, sister, brother and one friend at the hotel. For a number of years he was periodically hospitalized for episodes of bizarre behavior despite concentrated efforts made by various social service and mental health staff. This pattern can partially be attributed to the fact that, with the exception of his hotel buddy, A.P.'s social network was a very stressful one, as his family made frequent demands on A.P.'s time and money. Eventually, A.P. met a friend who was the leader of a drinking group of other hotel residents. This resulted in A.P.'s decreasing isolation as he soon became a member of this group. After meeting this group, A.P.'s hospitalizations decreased in frequency. Soon, he became a member of yet another hotel group, with whom he reg-

ularly ate dinner. From this group he came in contact with people who helped him find temporary jobs, social activities and other types of aid. At the time this case study was written, A.P. had stayed out of the hospital for over a year.

Whether the development of A.P.'s social support system caused his decreasing hospitalizations or whether the lines of causation are reversed, is impossible to determine empirically. However, according to Sokolovsky, et.al. the subject himself believes that it was his newfound supportive friendships which enabled him to better cope with the life stresses of his illness, family and life situation.

Implications

It is becoming clear that the formal mental health service delivery system needs an adjunct in naturally occurring social systems. Additionally, it appears that the family alone is not enough. An effective social network must include friends, co-workers and other non-kin. However, a majority of mental health clients living in the community are often "trapped". There is little opportunity to meet others and many lack the self-assurance and social skills necessary to establish and maintain supportive friendships. While friends may have been made during the hospital stay, these people are often lost after discharge. Unemployment prevents job-based friendships from beginning and lack of money makes transportation and communication difficult at best.

What is needed is access to peers in a healthy environment. This access will hopefully lead to the development of mutually beneficial relationships. Without mutuality the client often becomes the passive recipient of services

rather than a co-equal partner and active friend. The effects of an unequal relationship are often the breaking of ties, a rapidly depleted support system and further confirmation of a person's helplessness, dependence and low self-esteem.

Professionals can assist the development of client social networks in a number of ways. One can work with existing networks or one can create new networks. The relationship between professionals and non-paid or natural helpers can vary according to the amount of control the professionals have over the helpers. It can be: (1) collegial or mutually independent with the staff providing only support and consultation to natural helpers, (2) it can be coordinative, in which there is equal authority for staff and natural helpers, but the staff coordinates the helpers' activities, or (3) it can be directive in which the staff assumes a more supervisory role in working with helpers.

Five types of approaches to social network intervention found by Froland, Pancoast, Chapman & Kimboko (1979) have been described as follows:

1. Personal Network Intervention - This approach focuses on the existing network of an individual client. Agency staff get to know helpers within the client's network and provide them with support and consultation.

2. Volunteer Linkage - This approach also focuses on an individual client's network. Professionals take a direct role in recruiting and possibly training people to provide support to the client.

3. Mutual Aid Networks - This method centers around a client population experiencing similar

problems. Professionals either collaborate with an existing self-help group or create a network among a group of clients. The second alternative may place the professionals in a more directive role.

4. Neighborhood Helpers - Here a particular geographical locality is involved. Professionals usually seek out natural helpers within an existing helping network and form collegial relationships in which they strengthen or support the natural helpers.

5. Community Empowerment - Helping networks are created or organized among community residents in order to develop a "community voice" or build a community's capacity for self help.

Experience has shown that personal network intervention and volunteer linking can be time consuming and expensive and that linkages do not necessarily remain when professional intervention ceases. The use of neighborhood helpers, though helpful in many cases, does not give clients equal status in the network since they are always more likely to be the ones to receive help. Community empowerment is more oriented to community issues and tends to focus less on individual and special group needs. Hence, the mutual aid network appears to be the most promising and most cost effective approach in helping mental health clients.

To conclude this paper a quote is given from the 1978 Report by the President's Commission on Mental Health.

> As we seek ways to improve mental health services, it is important to recognize the strengths and potential that various support networks bring to different communities and neighborhoods and to recognize the need to

develop linkages between these systems and the formal mental health services system.

...Personal and community supports... can provide a basic underpinning for mental health in our society. Personal and community supports, when they emphasize the strengths of individuals and families and not their weaknesses, and when they focus on health rather than sickness...contain a great potential for innovation and creative commitment in maintaining health and providing needed human services... The Nation can ill afford to waste such valuable resources. The Commission believes this is one of the most significant frontiers in mental health at all levels of care... (President's Commission Report, 1978, p. 14-15).

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